		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038083

Facility Name: Lexington of LaGrange

Address: 4735 Willow Springs Road (Number) LaGrange (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 352-6900 **Fax #** (708) 482-0239

IDPA ID Number: 363835751001

Date of Initial License for Current Owners: 07/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,679	7,655	3,667	25,001	8
9	SNF/PED					9
10	ICF	10,027	2,958	45	13,030	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,706	10,613	3,712	38,031	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.59%

D. How many bed-hold days during this year were paid by Public Aid?
194 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/31/92

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 40 and days of care provided 3,574

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	A. General Services											
1	Dietary	211,471	14,953	8,240	234,664		234,664		234,664			1
2	Food Purchase		146,990		146,990		146,990	(7,229)	139,761			2
3	Housekeeping	184,413	20,932		205,345		205,345		205,345			3
4	Laundry	36,906	13,977		50,883		50,883	(9,322)	41,561			4
5	Heat and Other Utilities			132,882	132,882		132,882	1,556	134,438			5
6	Maintenance	35,922		87,475	123,397		123,397	1,285	124,682			6
7	Other (specify):*											7
8	**TOTAL General Services**	468,712	196,852	228,597	894,161		894,161	(13,710)	880,451			8
	B. Health Care and Programs											
9	Medical Director			11,700	11,700		11,700		11,700			9
10	Nursing and Medical Records	1,660,860	100,895	5,770	1,767,525		1,767,525		1,767,525			10
10a	Therapy			284,322	284,322		284,322		284,322			10a
11	Activities	136,015	10,784	3,061	149,860		149,860		149,860			11
12	Social Services	28,513		2,303	30,816		30,816		30,816			12
13	Nurse Aide Training											13
14	Program Transportation			2,350	2,350		2,350		2,350			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,825,388	111,679	309,506	2,246,573		2,246,573		2,246,573			16
	C. General Administration											
17	Administrative	132,992		208,832	341,824		341,824	(208,832)	132,992			17
18	Directors Fees											18
19	Professional Services			31,936	31,936		31,936	885	32,821			19
20	Dues, Fees, Subscriptions & Promotions			16,701	16,701		16,701	1,602	18,303			20
21	Clerical & General Office Expenses	273,534	24,693	14,670	312,897		312,897	10,488	323,385			21
22	Employee Benefits & Payroll Taxes			309,154	309,154		309,154	29,659	338,813			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,343	2,343		2,343	814	3,157			24
25	Other Admin. Staff Transportation			263	263		263	4,707	4,970			25
26	Insurance-Prop.Liab.Malpractice			77,857	77,857		77,857	1,159	79,016			26
27	Other (specify):*											27
28	**TOTAL General Administration**	406,526	24,693	661,756	1,092,975		1,092,975	(159,518)	933,457			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,700,626	333,224	1,199,859	4,233,709		4,233,709	(173,228)	4,060,481			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of LaGrange #0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			29,338	29,338		29,338	103,635	132,973			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							178,195	178,195			32
33	Real Estate Taxes							221,437	221,437			33
34	Rent-Facility & Grounds			820,552	820,552		820,552	(820,552)				34
35	Rent-Equipment & Vehicles			3,029	3,029		3,029	320	3,349			35
36	Other (specify):*											36
37	**TOTAL Ownership**			852,919	852,919		852,919	(316,965)	535,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,345	1,969	83,314		83,314		83,314			39
40	Barber and Beauty Shops			17,305	17,305		17,305		17,305			40
41	Coffee and Gift Shops			2,728	2,728		2,728		2,728			41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* Nonallowable costs			(3,599)	(3,599)		(3,599)	3,599				43
44	**TOTAL Special Cost Centers**		81,345	78,080	159,425		159,425	3,599	163,024			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,700,626	414,569	2,130,858	5,246,053		5,246,053	(486,594)	4,759,459			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(294)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(9,322)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(13,243)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(809)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(900)	43		18
19	Entertainment				19
20	Contributions	(555)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,643)	43		24
25	Fund Raising, Advertising and Promotional	(5,066)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	14,542	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(2,003)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,293)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(465,301)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (465,301)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (486,594)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083
1/1/01 - 12/31/01 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(2,272)	19
Out of period legal fees	(497)	19
Deferred maintenance amortization	766	6
Total	(2,003)	

See Accountants' Compilation Report

Lexington of LaGrange

ID# 0038083

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(294)	0	0	0	0	0	0	0	0	0	0	(294)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9,322)	0	0	0	0	0	0	0	0	0	0	(9,322)	4
5	Heat and Other Utilities	0	0	1,556	0	0	0	0	0	0	0	0	1,556	5
6	Maintenance	0	0	519	0	0	0	0	0	0	0	0	519	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,616)	0	2,075	0	0	0	0	0	0	0	0	(7,541)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(208,832)	0	0	0	0	0	0	0	(208,832)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50	3,604	0	0	0	0	0	0	0	0	3,654	19
20	Fees, Subscriptions & Promotions	0	0	1,602	0	0	0	0	0	0	0	0	1,602	20
21	Clerical & General Office Expenses	0	74	10,414	0	0	0	0	0	0	0	0	10,488	21
22	Employee Benefits & Payroll Taxes	0	0	22,724	0	0	0	0	0	0	0	0	22,724	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	814	0	0	0	0	0	0	0	0	814	24
25	Other Admin. Staff Transportation	0	0	4,707	0	0	0	0	0	0	0	0	4,707	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,159	0	0	0	0	0	0	0	1,159	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	124	43,865	(207,673)	0	0	0	0	0	0	0	(163,684)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,616)	124	45,940	(207,673)	0	0	0	0	0	0	0	(171,225)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lexington of LaGrange** **#** **0038083** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	97,251	0	6,384	0	0	0	0	0	0	0	103,635	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,243)	190,811	0	627	0	0	0	0	0	0	0	178,195	32
33	Real Estate Taxes	0	220,552	0	885	0	0	0	0	0	0	0	221,437	33
34	Rent-Facility & Grounds	0	(820,552)	0	0	0	0	0	0	0	0	0	(820,552)	34
35	Rent-Equipment & Vehicles	0	0	0	320	0	0	0	0	0	0	0	320	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,243)	(311,938)	0	8,216	0	0	0	0	0	0	0	(316,965)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	3,569	30	0	0	0	0	0	0	0	0	0	3,599	43
44	**TOTAL Special Cost Centers**	3,569	30	0	0	0	0	0	0	0	0	0	3,599	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,290)	(311,784)	45,940	(199,457)	0	0	0	0	0	0	0	(484,591)	45

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	22.33%			Sambell of LaGrange		
John Samatas	22.33%	See attached Schedule B		Limited Partnership	LaGrange	Real Estate ptsp.
Cynthia Thiem	22.34%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
Jeffrey J. Bell Revocable Trust	8.25%			Lexington Financial		
Lawrence W. Bell Declaration of Trust	8.25%			Services, L.L.C. II	Lombard	Finance Co.
David S. Bell Declaration of Trust	8.25%					
Dorothy D. Bell Declaration of Trust	8.25%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 820,552	Sambell of LaGrange Limited Partnership	**	$	$ (820,552)	1
2	V	19	Professional fees		Sambell of LaGrange Limited Partnership	**	50	50	2
3	V	21	Bank charges		Sambell of LaGrange Limited Partnership	**	74	74	3
4	V	30	Depreciation		Sambell of LaGrange Limited Partnership	**	97,251	97,251	4
5	V	32	Interest expense		Sambell of LaGrange Limited Partnership	**	189,034	189,034	5
6	V	32	Amortization of mortgage costs		Sambell of LaGrange Limited Partnership	**	1,777	1,777	6
7	V	33	Property taxes		Sambell of LaGrange Limited Partnership	**	220,552	220,552	7
8	V	43	State replacement tax		Sambell of LaGrange Limited Partnership	**	30	30	8
9	V								9
10	V								10
11	V				** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				11
12	V				of Sambell of LaGrange Limited Partnership				12
13	V								13
14	Total			$ 820,552			$ 508,768	$ * (311,784)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083 **Schedule B**
1/1/01 - 12/31/01

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities - gas & electric	$	Royal Management Corp.	**	$ 1,376	$ 1,376	15
16	V	5	Utilities - water & sewer		Royal Management Corp.	**	180	180	16
17	V	6	Repairs & maintenance		Royal Management Corp.	**	361	361	17
18	V	6	Scavenger & exterminating		Royal Management Corp.	**	151	151	18
19	V	6	Security service		Royal Management Corp.	**	7	7	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	2,756	2,756	20
21	V	19	Professional fees		Royal Management Corp.	**	848	848	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	1,311	1,311	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	291	291	23
24	V	21	Bank charges		Royal Management Corp.	**	1,570	1,570	24
25	V	21	Communications		Royal Management Corp.	**	284	284	25
26	V	21	Office supplies & printing		Royal Management Corp.	**	3,387	3,387	26
27	V	21	Postage		Royal Management Corp.	**	1,430	1,430	27
28	V	21	Telephone		Royal Management Corp.	**	3,743	3,743	28
29	V	22	FICA		Royal Management Corp.	**	13,939	13,939	29
30	V	22	FUTA		Royal Management Corp.	**	288	288	30
31	V	22	SUTA		Royal Management Corp.	**	545	545	31
32	V	22	Insurance - W/C		Royal Management Corp.	**	176	176	32
33	V	22	Insurance - Hospitalization		Royal Management Corp.	**	5,821	5,821	33
34	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	1,955	1,955	34
35	V	24	Travel & seminar		Royal Management Corp.	**	814	814	35
36	V	25	Auto expense		Royal Management Corp.	**	4,707	4,707	36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 45,940	$ * 45,940	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance - general	$	Royal Management Corp.	**	$ 1,159	$ 1,159	15
16	V	30	Depreciation - vehicles		Royal Management Corp.	**	1,959	1,959	16
17	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	1,206	1,206	17
18	V	30	Depreciation - equipment		Royal Management Corp.	**	3,219	3,219	18
19	V	32	Interest		Royal Management Corp.	**	627	627	19
20	V	33	Property taxes		Royal Management Corp.	**	885	885	20
21	V	35	Equipment rental		Royal Management Corp.	**	320	320	21
22	V	17	Management	208,832	Royal Management Corp.	**		(208,832)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 208,832			$ 9,375	$ * (199,457)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	2	4.00%	Salary	$ 19,621	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10.00%	Salary	8,628	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10.00%	Salary	10,827	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10.00%	Salary	4,420	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6.00%	Salary	5,966	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 49,462		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083 **Schedule C**
1/1/01 - 12/31/01

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of Lake Zurich, Inc.	16,123	36,664	20,230	8,260	11,148	92,425
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	154,397	351,096	193,736	79,097	106,751	885,077

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	$ 26,007	$	39,785	$ 1,376	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397		39,785	180	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818		39,785	361	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851		39,785	151	4
5	6	Security Service	Bed Days	751,703	11	125		39,785	7	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068		39,785	2,756	6
7	19	Professional fees	Bed Days	751,703	11	16,027		39,785	848	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766		39,785	1,311	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496		39,785	291	9
10	21	Bank charges	Bed Days	751,703	11	29,664		39,785	1,570	10
11	21	Communications	Bed Days	751,703	11	5,359		39,785	284	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988		39,785	3,387	12
13	21	Postage	Bed Days	751,703	11	27,021		39,785	1,430	13
14	21	Telephone	Bed Days	751,703	11	70,716		39,785	3,743	14
15	22	FICA	Bed Days	751,703	11	263,374		39,785	13,939	15
16	22	FUTA	Bed Days	751,703	11	5,433		39,785	288	16
17	22	SUTA	Bed Days	751,703	11	10,292		39,785	545	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319		39,785	176	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982		39,785	5,821	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931		39,785	1,955	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373		39,785	814	21
22	25	Auto expense	Bed Days	751,703	11	88,927		39,785	4,707	22
23										23
24										24
25	TOTALS					$ 867,934	$		$ 45,940	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance - general	Bed Days	751,703	11	$ 21,896	$	39,785	$ 1,159	1
2	30	Depreciation - vehicles	Bed Days	751,703	11	37,022		39,785	1,959	2
3	30	Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		39,785	1,206	3
4	30	Depreciation - equipment	Bed Days	751,703	11	60,826		39,785	3,219	4
5	32	Interest	Bed Days	751,703	11	11,844		39,785	627	5
6	33	Property taxes	Bed Days	751,703	11	16,719		39,785	885	6
7	35	Equipment rental	Bed Days	751,703	11	6,049		39,785	320	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 177,145	$		$ 9,375	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C. II	x		Mortgage	Varies	12/29/98	2,990,000	2,761,853	12/29/2008	0.0675	189,034	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,990,000	$ 2,761,853			$ 189,034	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,777	10
11								Interest income offset			(13,243)	11
12								Allocated from management company			627	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,839)	14
15	TOTALS (line 9+line14)						$ 2,990,000	$ 2,761,853			$ 178,195	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 204,000	1
Allocated from Management Company		885	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 208,552	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,437	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 216,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 221,437	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	192,036	8
	1997	195,909	9
	1998	198,451	10
	1999	196,475	11
	2000	208,552	12

2000 taxes:	208,552
Estimated increase (4%):	1.04
Estimated 2001 taxes:	216,894
Use:	216,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-08-207-018-000	Land and building	$ 208,552.21	$ 208,552.21
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 68,214.22	$ 885.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 276,766.43	$ 209,437.21

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,992 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	40,000	1991	$ 500,000	1
2					2
3	TOTALS	40,000		$ 500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1992	1992	$ 2,661,448	$	35	$ 76,041	$ 76,041	$ 722,393	4
5	10		1995	1995	79,363	7,936	10	7,936		51,586	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1992	1,152		20	58	58	548	9
10	Building Improvements			1992	2,714		31	271	271	2,578	10
11	Building Improvements			1993	2,901		35	83	83	704	11
12	Leasehold Improvements			1994	6,402	640	10	640		4,802	12
13	Leasehold Improvements - Corner Guards			1996	2,195	219	10	219		1,207	13
14	Wiring			1998	3,378	338	10	338		1,182	14
15	Resurface & Restripe Parking Lot			1998	3,753	375	10	375		1,314	15
16	Lobby Tile			1998	19,488	1,949	10	1,949		6,171	16
17	Resurface & Restripe Parking Lot			2000	1,997	200	10	200		300	17
18	Automatic Door			2000	1,300	130	10	130		195	18
19	Kitchen Rehab			2001	1,441	72	10	72		72	19
20	Infrared curtains for elevator			2001	3,000	150	10	150		150	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocated from management company	1995	$ 5,313	$		$ 165	$ 165	$ 988	37
38	Allocated from management company	1996	4,326			133	133	680	38
39	Allocated from management company	1989	149			5	5	65	39
40	Allocated from management company - HVAC	1998	112			3	3	13	40
41	Allocated from management company - Offices	1999	283			9	9	19	41
42	Allocated from management company - Offices	2000	133			4	4	7	42
43	Allocated from management company	1987	27,347			846	846	11,978	43
44	Allocated from management company	1993	13			1	1	3	44
45	Allocated from management company	1995	616			19	19	102	45
46	Allocated from management company	1996	123			4	4	16	46
47	Allocated from management company - Sidewalk	1998	255			8	8	22	47
48	Allocated from management company - Roof	1998	9			1	1	2	48
49	Allocated from management company - Awnings	1999	71			2	2	5	49
50	Allocated from management company - Parking lot	1999	160			5	5	38	50
51	Allocated from management company - Facade	2001	24			1	1	1	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,829,466	$ 12,009		$ 89,667	$ 77,658	$ 807,141	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 307,491	$ 15,422	$ 36,220	$ 20,798	5-10 years	$ 252,340	71
72	Current Year Purchases	19,075	1,907	1,907		5 years	1,907	72
73	Fully Depreciated Assets	11,677					11,677	73
74	Allocated from Management Company	34,777		3,220	3,220		25,271	74
75	TOTALS	$ 373,020	$ 17,329	$ 41,347	$ 24,018		$ 291,195	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			15,743		1,959	1,959		10,255	79
80	TOTALS			$ 15,743	$	$ 1,959	$ 1,959		$ 10,255	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,718,229	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,338	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,973	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 103,635	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,108,591	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehab	$ 103,039	92
93	Bed Additions	4,734	93
94			94
95		$ 107,773	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,349 Description: Copier - $2,465; Postage Meter - $564; Allocated from Management Company - $320
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	11,989	$ 121,803	$	11,989	$ 121,803	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		865	13,533		865	13,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		11,674	148,986		11,674	148,986	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				73,915		73,915	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					1,969	7,430		9,399	13
14	TOTAL			$	24,528	$ 286,291	$ 81,345	24,528	$ 367,636	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083
1/1/01 - 12/31/01

Schedule D

XIV. Special Services
Line 13, Other:

Service	Cost	Supplies	Line Reference
Oxygen		7,430	L39, C 2
Radiology	539		L39, C3
Laboratory	1,430		L39, C3
Total	1,969	7,430	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 165,295	$ 181,682	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,098,391	1,098,391	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,628	35,628	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	15,350	15,350	8
9	Other(specify): Escrows		76,522	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,314,664	$ 1,407,573	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,263	3,263	12
13	Land		500,000	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	122,317	165,117	15
16	Equipment, at Historical Cost	122,882	388,763	16
17	Accumulated Depreciation (book methods)	(128,628)	(1,108,591)	17
18	Deferred Charges		714	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Construction in progr	107,773	107,773	22
23	Other(specify): Unamortized loan costs		30,202	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 227,607	$ 2,751,590	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,542,271	$ 4,159,163	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 271,480	$ 271,480	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,684	108,684	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,736	1,736	31
32	Accrued Real Estate Taxes(Sch.IX-B)		216,000	32
33	Accrued Interest Payable		15,535	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(13,300)	(13,300)	35
	Other Current Liabilities(specify):			
36	See attached Schedule E	167,018	67,704	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 535,618	$ 667,839	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,761,853	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,761,853	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 535,618	$ 3,429,692	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,006,653	$ 729,471	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,542,271	$ 4,159,163	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083
1/1/01 - 12/31/01 **Schedule E**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	99,314	-
Accrued management fees	17,048	17,048
Accrued 401 (k) contribution	15,492	15,492
401 (k) withholding	3,558	3,558
Other accrued expenses	15,381	15,381
Due to related parties	16,225	16,225
Total line 36	167,018	67,704

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Bed Hold	33,184
Investment Income	837
Miscellaneous Income	2882
Total line 28	36,903

See Accountants' Compilation Report

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 909,153	1
2	Restatements (describe):		2
3	**Prior year's post closing entries**	(60,554)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 848,599	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	914,054	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(756,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 158,054	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,006,653	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,679,446	1
2	Discounts and Allowances for all Levels	(288,953)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,390,493	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	518,938	6
7	Oxygen	1,715	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 520,653	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,326	12
13	Barber and Beauty Care	21,380	13
14	Non-Patient Meals	294	14
15	Telephone, Television and Radio	13	15
16	Rental of Facility Space		16
17	Sale of Drugs	102,361	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,204	19
20	Radiology and X-Ray	569	20
21	Other Medical Services	56,346	21
22	Laundry	9,322	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198,815	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13,243	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,243	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	36,903	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 36,903	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,160,107	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	894,161	31
32	Health Care	2,246,573	32
33	General Administration	1,092,975	33
	B. Capital Expense		
34	Ownership	852,919	34
	C. Ancillary Expense		
35	Special Cost Centers	99,748	35
36	Provider Participation Fee	59,677	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,246,053	40
41	**Income before Income Taxes (line 30 minus line 40)****	914,054	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 914,054	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,992	2,097	$ 64,031	$ 30.53	1
2	Assistant Director of Nursing	1,899	2,092	52,757	25.22	2
3	Registered Nurses	20,526	22,365	517,949	23.16	3
4	Licensed Practical Nurses	17,896	18,859	354,646	18.81	4
5	Nurse Aides & Orderlies	55,225	57,796	610,785	10.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,745	5,093	60,692	11.92	8
9	Activity Director	1,328	1,334	18,135	13.59	9
10	Activity Assistants	12,979	13,389	117,880	8.80	10
11	Social Service Workers	1,978	2,132	28,513	13.37	11
12	Dietician	55	59	1,639	27.78	12
13	Food Service Supervisor	2,844	2,949	44,816	15.20	13
14	Head Cook	2,027	2,051	19,996	9.75	14
15	Cook Helpers/Assistants	11,049	11,774	89,349	7.59	15
16	Dishwashers	8,396	8,834	55,671	6.30	16
17	Maintenance Workers	2,652	2,738	35,922	13.12	17
18	Housekeepers	24,896	26,442	184,413	6.97	18
19	Laundry	5,392	5,816	36,906	6.35	19
20	Administrator	2,050	2,098	83,530	39.81	20
21	Assistant Administrator					21
22	Other Administrative	363	364	49,462	135.88	22
23	Office Manager					23
24	Clerical	17,458	18,533	273,534	14.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,750	206,815	$ 2,700,626 *	$ 13.06	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,240	L 1, C 3	35
36	Medical Director	Monthly	11,700	L 9, C 3	36
37	Medical Records Consultant	13	650	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,061	L 11, C 3	44
45	Social Service Consultant	Monthly	2,303	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	13	$ 27,154		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Morris	Administrator	0.00%	$ 83,530
John Samatas	Admin/Plant Ops	22.33%	8,628
James Samatas	Administrative	22.33%	19,621
Cynthia Thiem	Administrative	22.34%	10,827
George Samatas	Administrative	0.00%	4,420
Jason Samatas	Administrative	0.00%	5,966
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 132,992

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 208,832
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 208,832

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Bus. Svs.	Accounting	$ 6,635
Altschuler, Melvoin & Glasser LLP	Accounting	13,358
Aetna Life Insurance & Annuity	401(k) administration	495
Sachnoff & Weaver	Legal	3,217
Freedman, Anselmo & Lindberg	Collections	2,272
Environetx	Space Consulting	242
Personnel Planners	U/C Consulting	670
James Samatas	Legal	50
Royal Management Corp.	Web site development	369
Robert Stachura	Accounting	27
Systematic Management	Billing Consultant	689
See attached Schedule F		3,912
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 31,936

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,588
Unemployment Compensation Insurance	15,253
FICA Taxes	199,222
Employee Health Insurance	65,445
Employee Meals	6,935
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	16,738
Other Employee Benefits	6,632
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,813

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	15,366
Health Care Worker Background Check (Indicate # of checks performed 34)	408
Miscellaneous Licenses & Permits	265
Miscellaneous Dues & Subscriptions	262
Allocated from Management Company	1,602
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,303

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,343
Allocated from Management Company	814
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,157

* Attach copy of IMRF notifications

**See instructions.

Lexington Health Care Center of LaGrange, Inc.
Provider # 0038083 **Schedule F**
1/1/01 - 12/31/01

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Advanced Information Management	Computer Consulting	2,735
Information Controls, Inc.	Computer Consulting	1,177
Total Other Professional Services		3,912
Total, Agrees to Schedule V, Line 19, Column 3		31,936
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	549
James Samatas	Filing and recording fees	2
Sachnoff & Weaver	Legal	27
BDO Seidman, LLP	Accounting	7
Robert Stachura	Accounting	1
Pension Administrators / Aetna Life Ins & Annuity	401 (k) Administration	116
Various	Consulting	146
Various	Computer Services	2,756
Allocated from building partnership		
James Samatas, Attorney at Law	Legal	50
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(2,272)
Sachnoff & Weaver	Out of period legal fees	(497)
Total, Agrees to Schedule V, Line 19, Column 8		32,821

See Accountants' Compilation Report.

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred Maintenance	Sept., 1998	$ 1,742	3 years	$ 290	$ 581	$ 581	$ 290	$	$	$	$	$
2	Painting & Decorating	Various 2000	1,428	3 years			238	476	476	238			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,170		$ 290	$ 581	$ 819	$ 766	$ 476	$ 238	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,262** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,677**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,935** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **294**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	211,471	14,953	8,240	234,664	0	234,664	0	234,664
2. Food Pr	0	146,990	0	146,990	0	146,990	-7,229	139,761
3. Housek	184,413	20,932	0	205,345	0	205,345	0	205,345
4. Laundry	36,906	13,977	0	50,883	0	50,883	-9,322	41,561
5. Heat an	0	0	132,882	132,882	0	132,882	1,556	134,438
6. Mainten	35,922	0	87,475	123,397	0	123,397	1,285	124,682
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	468,712	196,852	228,597	894,161	0	894,161	-13,710	880,451
9. Medical	0	0	11,700	11,700	0	11,700	0	11,700
10. Nursin	1,660,860	100,895	5,770	1,767,525	0	1,767,525	0	1,767,525
10a. Thera	0	0	284,322	284,322	0	284,322	0	284,322
11. Activiti	136,015	10,784	3,061	149,860	0	149,860	0	149,860
12. Social	28,513	0	2,303	30,816	0	30,816	0	30,816
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	2,350	2,350	0	2,350	0	2,350
15. Other	0	0	0	0	0	0	0	0
16. Total H	1,825,388	111,679	309,506	2,246,573	0	2,246,573	0	2,246,573
17. Admin	132,992	0	208,832	341,824	0	341,824	-208,832	132,992
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	31,936	31,936	0	31,936	885	32,821
20. Fees,	0	0	16,701	16,701	0	16,701	1,602	18,303
21. Clerica	273,534	24,693	14,670	312,897	0	312,897	10,488	323,385
22. Emplo	0	0	309,154	309,154	0	309,154	29,659	338,813
23. Inservi	0	0	0	0	0	0	0	0
24. Travel	0	0	2,343	2,343	0	2,343	814	3,157
25. Other	0	0	263	263	0	263	4,707	4,970
26. Insura	0	0	77,857	77,857	0	77,857	1,159	79,016
27. Other	0	0	0	0	0	0	0	0
28. Total (	406,526	24,693	661,756	1,092,975	0	1,092,975	-159,518	933,457
29. Total (	2,700,626	333,224	1,199,859	4,233,709	0	4,233,709	-173,228	4,060,481
30. Depre	0	0	29,338	29,338	0	29,338	103,635	132,973
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	0	0	0	0	178,195	178,195
33. Real E	0	0	0	0	0	0	221,437	221,437
34. Rent -	0	0	820,552	820,552	0	820,552	-820,552	0
35. Rent -	0	0	3,029	3,029	0	3,029	320	3,349
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	852,919	852,919	0	852,919	-316,965	535,954
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	81,345	1,969	83,314	0	83,314	0	83,314
40. Barber	0	0	17,305	17,305	0	17,305	0	17,305
41. Coffee	0	0	2,728	2,728	0	2,728	0	2,728
42. Provid	0	0	59,677	59,677	0	59,677	0	59,677
43. Other	0	0	-3,599	-3,599	0	-3,599	3,599	0
44. Total S	0	81,345	78,080	159,425	0	159,425	3,599	163,024
45. Grand	2,700,626	414,569	2,130,858	5,246,053	0	5,246,053	-486,594	4,759,459

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	165,295	181,682
2. Cash - F	0	0
3. Account	1,098,391	1,098,391
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	35,628	35,628
7. Other Pr	0	0
8. Account	15,350	15,350
9. Other (s	0	76,522
10. Total cı	1,314,664	1,407,573
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	3,263	3,263
13. Land	0	500,000
14. Buildin	0	2,664,349
15. Leaseh	122,317	165,117
16. Equipn	122,882	388,763
17. Accum	-128,628	########
18. Deferre	0	714
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	107,773	107,773
23. other (s	0	30,202
24. Total L	227,607	2,751,590
25. Total A	1,542,271	4,159,163
CURRENT LIABILITIES		
26. Accour	271,480	271,480
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	108,684	108,684
31. Accrue	1,736	1,736
32. Accrue	0	216,000
33. Accrue	0	15,535
34. Deferre	0	0
35. Federa	-13,300	-13,300
36. Other C	167,018	67,704
37. Other C	0	0
38. Total C	535,618	667,839
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	2,761,853
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	0	2,761,853
46.Total Li	535,618	3,429,692
47.Total Eo	1,006,653	729,471
48.Total Li	1,542,271	4,159,163

		Balance per Medicaid Trial Balance
1.	Gross F	5,679,446
2.	Discour	-288,953
	Subtota	5,390,493
4.	Day Ca	0
5.	Other C	0
6.	Therapy	518,938
7.	Oxygen	1,715
	Subtota	520,653
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	2,326
13.	Barber	21,380
14.	Non-P	294
15.	Teleph	13
16.	Rental	0
17.	Sale o	102,361
18.	Sale o	0
19.	Labora	6,204
20.	Radiol	569
21.	Other	56,346
22.	Laund	9,322
	Subtot	198,815
24.	Contril	0
25.	Interes	13,243
	Subtot	13,243
27.	Other	36,903
28.	Other	0
	Subtot	36,903
30.	Total F	6,160,107
31.	Gener	894,161
32.	Health	2,246,573
33.	Gener	1,092,975
34.	Owner	852,919
35.	Specia	99,748
35.	Provid	59,677
37.	Other	0
40.	Total E	5,246,053
41.	Incom	914,054
42.	Incom	0
43.	Net In	914,054

Page

1

2
3
4
5
6
7
8
9
10 Attachment of Real Estate Bill and fill out form

11
12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
13
14
15
16
17
18
19 The bottom right side of page under **, you must write in any comments
20
21
22
23

RECONCILIATION REPORT **Lexington of LaGrange** **03:15 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-486,594	equal to	-486,594	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	178,195	equal to	178,195	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	221,437	equal to	221,437	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	132,973	equal to	132,973	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,349	equal to	3,349	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	284,322	equal to	284,322	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	81,345	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	894,161	equal to	894,161	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,246,573	equal to	2,246,573	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,092,975	equal to	1,092,975	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	852,919	equal to	852,919	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	99,748	equal to	99,748	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	59,677	equal to	59,677	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,600,168	equal to	1,660,860	-60,692	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	136,015	equal to	136,015	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	28,513	equal to	28,513	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	211,471	equal to	211,471	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	35,922	equal to	35,922	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	184,413	equal to	184,413	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	36,906	equal to	36,906	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	132,992	equal to	132,992	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	273,534	equal to	273,534	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,700,626	equal to	2,700,626	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,240	< or = to	8,240	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,700	< or = to	11,700	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,850	< or = to	5,770	-3,920	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,061	< or = to	3,061	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,303	< or = to	2,303	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	132,992	equal to	132,992	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	208,832	equal to	208,832	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	31,936	equal to	31,936	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	338,813	equal to	338,813	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	18,303	equal to	18,303	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,157	equal to	3,157	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	59,677	equal to	59,677	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	6,935	< or = to	29,659	-22,724	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	6,935	equal to	6,935	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,574	equal to	3,667	-93	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-465,301	equal to	-465,301	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,761,853	equal to	2,761,853	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	216,000	equal to	216,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	500,000	equal to	500,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,829,466	equal to	2,829,466	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	388,763	equal to	388,763	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,108,591	equal to	1,108,591	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,006,653	equal to	1,006,653	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	914,054	equal to	914,054	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	714	equal to	714	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,542,271	equal to	1,542,271	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1